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ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Cameron Dow, DVM
Brian Sidaway, DVM

STAFF PRESENT: Tracy A. Riendeau, CVT - Investigations
Marc Harris, Assistant Attorney General

RE: Case: 21-46
Complainant(s): Frederick Milens/Ashanna Biliter
Respondent(s): Nicolette Meredith, DVM (License: 6393)

SUMMARY:
Complaint Received at Board Office: 10/16/20
Committee Discussion: 4/6/21
Board IIR: 5/19/21

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On June 19, 2020, "C[redacted]" a 14-year-old male Pomeranian was presented to 1st Pet Veterinary Centers after two day history of collapsing. The dog had multiple medical issues and was under the care of an internal medicine specialist and neurologist.

Diagnostics were conducted; it was initially suspected the dog had IMHA and a blood transfusion was eventually performed at BluePearl.

The dog continued to decline, was evaluated and hospitalized for care and treatment at 1st Pet Veterinary Centers for possible seizures. The dog was obtunded and worsened despite treatment. All of the dog's care providers were concerned with the dog's prognosis and quality of life due to the dog's mental status not returning.

On June 26, 2020, Complainants elected to humanely euthanize the dog.

Complainants were noticed and appeared telephonically with attorney, Kyle O'Dwyer.
Respondent was noticed and appeared telephonically. Attorney David Stoll appeared.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: Frederick Milens/Ashanna Biliter
- Respondent(s) narrative/medical record: Nicolette Meredith, DVM
- Consulting Veterinarian(s) narrative/medical records: Jill Patt, DVM

PROPOSED 'FINDINGS of FACT':

With respect to Dr. Meredith, Complainants allege that Dr. Meredith failed to administer the dog any medication for almost half a day, making it difficult to determine what was causing the dog's issues. Additionally, Complainants allege that the dog was not monitored closely; there was not a "jingle collar" or other device used to inform them when the dog was having a seizure.

Complainants were also concerned that Dr. Meredith failed to coordinate with an internal medicine specialist or critical care doctor despite her assertion the she would do so. Additionally, Complainants believe she failed to relay any of Dr. Schnier's recommendations to Complainants, nor did she update Complainants of the dog's severe decline as requested.

1. Dr. Schnier stated that he had worked with the complainants since the fall of 2018 as an internal medicine specialist. At that time, the dog was evaluated at VETMED where he was diagnosed with a pheochromocytoma involving his left adrenal gland. The pheochromocytoma was resected by a surgeon at UC Davis in December 2018. Dr. Schnier continued to work with the dog and his owners since that time and had re-evaluated the dog numerous times at VETMED and later at BluePearl.

2. Dr. Yeamans stated in her narrative that the dog had been under her premises's care for progressive seizure disorder and suspected meningoencephalitis of unknown origin since November 2019.

3. On June 19, 2020, Friday, (approx. 4:30pm) the dog was presented to Dr. Meredith at 1st Pet Veterinary Centers after collapsing. The dog had a history of multiple medical issues and had been on a combination of seizure medication. Complainants reported that the dog laid lateral in the yard and had turned his head to the side. The dog also had two previous episodes at home that started the night before. There was also an episode that happed later in the day where the dog had urinated on himself and turned pale. Upon exam, Dr. Meredith noted the dog was responsive, had muddy gums and breathing difficulties. The dog's neurological exam was abnormal – non menace response in either eye. The dog's heart rate was low and lungs harsh. An IV catheter was placed and the dog was put in an oxygen chamber.

4. On intake the dog had a respiration rate = 30rpm, white mucous membranes, pulse rate = 80bpm (the minutes later 150bpm); temperature = unable to obtain. After being placed in

the oxygen chamber, ECG revealed a normal rhythm and rate, as well as normal blood pressure. Once the dog had received oxygen therapy, blood was collected for testing and thoracic radiographs were performed.

5. Radiographs revealed a mildly enlarged heart with a bronchial pattern worse in the left lung fields, spondylosis, and aeophagia. The radiology report noted collapse of the left bronchius, enlarged liver, and some abnormal gastric contents. Blood work revealed anemia (PCT – 22%, RBC – 2.47), and a saline agglutination test was run and there was a concern for agglutination.

6. Dr. Meredith discussed the abnormal findings with Complainants. Complainants advised Dr. Meredith that the dog had kidney disease as well as a left sided stroke and absent menace of the right eye. Dr. Meredith relayed the possibility of immune mediated hemolytic anemia (IMHA) due to the anemia and elevated WBC - she felt that primary IMHA was unlikely due the dog's age, and secondary IMHA could be related to an underlying infection, medications, cancer, and other. Dr. Meredith also expressed concern for pulmonary thromboembolism (PTE), considering the dog's history of stroke and oxygen dependence.

7. Dr. Meredith discussed at length possible underlying causes, and that they could treat with steroids, antibiotics, and oxygen at that time. They would continue to monitor the dog's response. Due to the dog's myriad of other health issues, the dog's prognosis was guarded to poor, and Complainants were advised that if the dog continued to have issues, they may need to discuss the dog's quality of life. Complainants understood and approved the plan for hospitalization. The dog was hospitalized on IV fluids 8.8mLs/hr (unclear on type).

8. At 7:00pm, Dr. Meredith's associate, Dr. Deer, took over the care of the dog. Dr. Deer stated in her narrative that dog had an extensive history of hydrocephalus, seizures, Chiarai malformation, syringomyelia, medially luxating patellas, hypertension, hypothyroidism, collapsing trachea, IVDD, a surgically removed pheochromocytoma a few years prior, and a suspected fractured right thoracic limb (prior to adoption of the dog). The dog had elevated renal values that have been identified by the regular veterinarian earlier in the year. The night before presentation the dog had a seizure with collapse and white mucous membranes. The dog had been unable to stand which was normal for him as he had not been ambulatory for some time.

9. After Dr. Deer reviewed Dr. Meredith's findings (blood work and radiograph results), she examined the dog and found a weight = 3.4kg, a temperature = 98.2 degrees, a heart rate = 170bpm and a respiration rate = 40rpm; pale mucous membranes. Dr. Deer stated the dog was quiet, alert, and responsive; although the dog became tachypneic during the exam but was not in respiratory distress. The dog was non-ambulatory and Dr. Deer did not perform a full neurologic exam due to the dog needing to be in the oxygen chamber. The dog was offered food and water – ate well – and was medicated with prednisone, zonisamide,

levothyroxine, imepitoin, flowvent, and telmisartan at 8pm.

10. That evening, dog was also administered Ampicillin, levetiracetam and dexamethasone sodium phosphate IV.

11. In the early morning, blood work was repeated. When removed from the oxygen kennel the dog would become stressed therefore the dog remained on oxygen. Blood work revealed PCV 20% and Dr. Deer contacted Complainants. She relayed the worsening anemia and the differential diagnosis of IMHA and causes. Complainants asked if the zonisamide or phenobarbital could be the cause – Dr. Deer thought it was unlikely but they could try tapering zonisamide if recommended by the neurologist, but the dog would at risk for continued seizures. Additionally, stopping the zonisamide would not slow the IMHA if that was the cause. Due to the worsening anemia, blood transfusion was discussed as a possibility as well as the dog's quality of life and humane euthanasia. Complainants were not interested in humane euthanasia at that time.

12. Complainant requested Dr. Deer reach out to Dr. Schnier – internal medicine at BluePearl Avondale - and Dr. Yeamans – neurologist at ANIC – to discuss next steps. Dr. Deer explained that she would not be able to get ahold of either of them at that time (1am) but she would call BluePearl to update them. Within the hour, Dr. Deer called BluePearl to advise the dog was currently being hospitalized with them and to let Dr. Schnier know that Complainants were interested in consulting with him.

13. On June 20, 2020, at approximately 6:30am, Dr. Deer contacted Complainants with an update on the dog. She advised that the dog was still on oxygen therapy and that she had reached out to BluePearl to let them know the dog was hospitalized with them. It was unlikely they would get a consult on the weekend, but they would let Dr. Schnier know. Dr. Deer discussed the plan of potentially lowering the zonisamide and that the blood work was partially consistent with IMHA but was not the definitive diagnosis. Shortly after the call, the dog's care was transferred to Dr. Meredith.

14. At 8:00am, the dog was medicated with the owner's medication and Dr. Meredith continued supportive care for the dog throughout the day.

15. At 11:00am the dog had a PCV = 22% and at 3:00pm the dog had a PCV at 23%. Attempts were made to wean the dog off oxygen throughout the day. Complainants visited the dog and elected to take the dog home as he appeared more relaxed while with them. Dr. Meredith recommended Complainants keep their previously scheduled appointment with Dr. Schnier on Monday. The dog was discharged to Complainants.

16. On June 21, 2020, at 4:00am, the dog presented to Dr. Deer at 1st Pet Veterinary Centers due to another episode of collapse. Complainants reported that they took the dog outside where he collapsed, was pale and non-responsive. According to Dr. Deer, she evaluated

the dog – he was QAR, unable to ambulate, was tachypnic, and had mild to moderate increased abdominal effort with an increase in bronchovesicular sounds in all lungs. The dog had a PCV – 22% consistent with the last reading the previous day. Could not locate the medical record for this day.

17. Dr. Deer spoke with Complainants and discussed that the dog appeared to be back to the same condition he was the previous day. They discussed causes of the dog's collapse and hospitalization for care until the evaluation at BluePearl. They further discussed a cardiology consult to evaluate pulmonary hypertension and if there was cardiac issues. Complainants were interested in the cardiology consult. Since it was Sunday at 4am, Dr. Deer explained that it was unlikely they could secure a consult right away. The dog was given back to Complainants to wait in the car while Dr. Deer reached out to specialists.

18. Dr. Deer reached out to Dr. Church – he was out of town; she contacted VETMED and was advised that an echocardiogram and cardiology consult was unlikely on Sunday or Monday. Dr. Deer reported her unsuccessful attempts to find a cardiology consult for Complainants and recommended follow up care at VETMED until the cardiologist could evaluate the dog. Complainants elected to take the dog home and monitor him.

19. Complainants called BluePearl to advise the dog was being seen at 1st Pet Veterinary Centers in Mesa and asked if Dr. Schnier could call and discuss the dog's care with the vets at 1st Pet Veterinary Centers. BluePearl staff advised Complainants that Dr. Schnier was not on-call but they would text Dr. Schnier and let him know the issues the dog was having. However, the dog issues were new and Dr. Schnier would not be able to provide any information other than the dog's history. BluePearl staff would call 1st Pet Veterinary Centers to discuss.

20. BluePearl staff called 1st Pet Veterinary Centers and spoke with Dr. Deer. She was advised that Dr. Schnier was not on call all the time but would be texted to update him on the dog. Dr. Deer reported that the dog had been presented a few days ago and it was recommended Complainants follow up with an internal medicine doctor which was not done – however the dog would be seen on Monday. Dr. Deer further stated that Complainants were having difficulty understanding that it might be time.

21. Complainants stated that Dr. Deer did not inform them of her opinion at that time. If she had, they would have had sought out a different provider.

22. At 7:00pm that evening, Dr. Deer returned to work. She had a message from Complainants; she returned the call and was told that the dog was okay but sedate. They were unsure if the dog was sedate due to the illness or the medications – the dog was resting well and eating and drinking.

23. On June 22, 2020, the dog was presented to Dr. Schnier for evaluation. Dr. Schnier

reviewed the dog's diagnosis/problem list:

a. Hind limb neuropathy/myopathy;
b. Pheochromocytoma;
c. Tracheal Collapse at level of mainstem bronchus and intrathoracic;
d. Spondylosis Deformans Multilevel – cervical – sever, LS – mild;
e. Hydrocephalus – congenital COMS;
f. Patella luxation bilateral;
g. Previous right front leg trauma with resultant valgus deformity;
h. History of seizures with recent onset of grand mal and focal seizures;
i. Intermittent hyponatremia/hypochloremia/hyperkalemia;
j. Hypothyroid;
k. Proteinuria;
l. Cortical blindness OD;
m. History of hypertension – now borderline hypotensive;
n. Recent onset of lethargy, intermittent collapse and vomiting;
o. Elevated Spec cPl consistent with pancreatitis;
p. New onset of severe non-regenerative anemia;
q. Leukocytosis with a mild left shift;
r. Concern for pulmonary hypertension; and
s. Generalized poor lung inflation.

24. Dr. Schnier reviewed the dog's recent history of collapse and apnea. He was treated at 1st Pet Veterinary Centers and severe non-regenerative anemia was identified. The dog had been hospitalized for diagnostics and treatment. No blood transfusion was performed at that time. After discharge, the dog had another episode of collapse with a period of apnea. Dr. Schnier mentioned that the dog may have experienced a mild seizure following one of his episodes – Complainants reported that the dog had been experiencing seizures every 5 – 6 weeks. Previous seizure was in May and the last cluster seizure occurred in March. The dog was on the following medications:

a. Imepitoin;
b. Levetiracetam;
c. Zonisamide;
d. Prednisone;
e. Omeprazole;
f. Levothyroxine;
g. Telmisartan;
h. Amlodipine;
i. FloVent;
j. Denamarin;
k. Clavacillin;
l. Hydrocodone;
m. Entyce; and

n. Diazepam rectal gel.

25. Dr. Schnier examined the dog (W-3.5kg, T-103.2, P-120, R-90); he noted that the dog was subdued but responsive. He was unable to walk in the hospital and demonstrated difficulty standing – carpal valgus was noted, mostly in the right forelimb. The hind limbs contracted forward. Mucous membranes were pink and a soft grade II/VI left systolic murmur was suspected on auscultation with a sinus arrhythmia. Lungs ausculted clear in all fields although intermittent episodes of panting and tachypnea were noted with increased respiratory effort at times.

26. Dr. Schnier performed radiographs and an ultrasound on the dog. Radiographs revealed generalized poor lung inflation consistent with recumbency and possibly exacerbated by concurrent tracheal collapse. Associated right cranial atelectasis. Concurrent mild diffuse tracheobronchitis and mild right cranial pneumonia were possible. There was a nonspecific hepatopathy which could be associated with any infiltrative process. Elbow arthritis, Patella luxation, and multifocal cervical and thoracolumbar IVDD.

27. Abdominal ultrasound revealed:
Mild to moderate hepatomegaly was noted with hyperechoic parenchyma. The hepatic changes were suspected to represent a vacuolar hepatopathy. This could have been associated with chronic prednisone administration or possibly, underlying endocrine/metabolic disease. Bilateral renal changes were noted, consistent with chronic kidney disease. Renal size appeared to be stable. Two small non-deforming hypoechoic nodules were noted. The splenic nodules appeared to be consistent with a benign process. No abnormalities were noted to account for the dog's signs of anemia. Primary differentials include gastrointestinal blood loss vs hemolytic anemia.

28. Blood work and a urinalysis were performed. PCV = 23%; HCT = 17.8%; Cardiopet NT – proBNP -2407; fecal occult blood test – positive.

29. The dog was administered the following:
a. Oxygen therapy;
b. Iron dextran;
c. Cobalamin; and
d. LRS SQ;

30. Dr. Schnier discussed hospitalization and packed red blood cell transfusion with Complainants. Complainants wanted to avoid a transfusion at that time, however, a follow up appointment to have the dog's PCV rechecked on June 24^{ih} was scheduled. The dog was discharged with instructions for Complainants to monitor the dog and continue current medications but discontinue telmisartan and amolodipine. Complainants were to feed the dog a low-fat diet. Detailed discharge instructions were provided to Complainants with the dog's diagnostic results. An echocardiogram with a cardiologist was recommended and if

the follow up blood work revealed progressive anemia, a blood transfusion could be warranted.

31. On June 23, 2020, the dog was presented to Dr. Matthews at VETMED for an echocardiogram. The echo revealed left ventricular hypertrophy, mild valve insufficiency and moderate pulmonary hypertension.

32. On June 24, 2020, the dog was presented to Dr. Schnier for a recheck. Upon exam, the dog had a weight = 3.4kg, a temperature = 101 degrees, a pulse rate = 132bpm and a respiration rate = 90bpm. The rest of the exam was noted to be the same as the June 22nd exam. PCV = 17%; TS – 6.2. Dr. Schnier discussed the blood results with Complainants and recommended a blood transfusion as the dog's anemia had progressed since 6/22. The dog would be hospitalized for the transfusion and if no complications occurred the dog would be discharged later that day.

33. The dog was hospitalized for the blood transfusion. No complications had occurred and the dog was discharged later that evening. During the hospitalization, the dog was also administered:

a. Sucralfate;
b. Levetiracetam;
c. Denamarin;
d. Orbax;
e. Dex SP;
f. Cyclosporine; and
g. Clopidogrel.

34. Discharge instructions were provided which were also discussed with Complainants. They stated that Dr. Yeamans was contacted regarding the dog's condition - she indicated that the zonisamide could have possibly triggered the dog's anemia and that it would be reasonably safe to discontinue zonisamide at this time. However, phenobarbital may need to be restarted if recurrent seizure activity was noted. The dog's fecal occult test was positive indicating a possibility of gastrointestinal bleeding; however, melena and GI signs would be expected with the dog's current level of anemia if GI bleeding was responsible for the dog's signs. A recheck PCV and blood pressure was recommended on June 26th or sooner if the dog was not doing well. Discharge instructions included a medication table that noted the recent changes to the dog's medications.

35. Dr. Schnier stated in his narrative that prior to discharge of the animal, he advised Complainants that BluePearl was staffed 24 hours a day with veterinarians and staff and they could call anytime with questions or concerns. If the call was outside normal business hours, they would speak with ER department staff. Dr. Schnier stated that he did not indicate that he would personally be in the hospital or available 24 hours to speak with Complainants directly. However, Dr. Schnier stated that he typically can be contacted by BluePearl staff by

phone outside of his normal hours.

36. Later that evening, at 9:40pm, the dog was presented to Dr. Deer due to a suspected seizure. The dog presented obtunded and minimally responsive. Complainants reported that the dog had a seizure at home and therefore rectal diazepam was administered. Upon exam, the dog had a weight = 3.3kg, a temperature = 104.2 degrees, a heart rate = 150bpm and a respiration rate = > 60rpm. Dr. Deer noted the dog appeared dehydrated based on tacky mucous membranes and prolonged skin tenting. The gums were pale and scant hematochezia was noted on the thermometer. An IV catheter was placed; the dog was started on Normosol – R fluids and placed on oxygen while Dr. Deer spoke with Complainants.

37. Dr. Deer stated in her narrative that she was frank with Complainants and expressed concerns about the chances of the dog surviving the night. Complainants felt the dog still had some fight left in him and approved overnight care. The dog was started on injectable levetiracetam since the dog was too obtunded to eat/swallow – oral medications were placed on the dog's treatment sheet with strict instructions to consult with the attending veterinarians prior to administration due to his obtunded status and high risk of choking. The dog's oral medications were not administered during her shift due to the dog being too obtunded to eat. Keppra and pantoprazole were given to the dog IV.

38. The dog remained obtunded throughout the night but the elevated temperature resolved with IV fluids and supportive care. Food was not offered as the dog was too obtunded to swallow.

39. At 12:44am (6/25), Complainants were updated and advised that there were no further seizures, the dog was in still in oxygen and critical. They asked about the dog's current PCV – Dr. Deer explained that the dog was not stable enough to remove from oxygen and collect a blood sample, which could put the dog at risk for another respiratory episode. While monitoring the PCV was important, Dr. Deer did not want to worsen the dog's condition.

40. At 5:00am, the dog appeared more sedate that previously – blood pressure was too low to read on the Doppler and his heart rate dropped to 70. Three doses of bolus fluids were administered which brought the dog's blood pressure up – the dog's PCV = 49%; TP = 5.

41. At 6:24am, Dr. Deer called Complainants when she felt the dog was stable enough to step away. She discussed the dog's episode of hypotension, bradycardia and the use of IV fluids. Dr. Deer relayed that there was a delicate balance of fluid overload due to the dog being diagnosed with pulmonary hypertension and mitral valve regurgitation recently. Additionally, the dog's PCV = 49% was indication that the dog's current symptoms were likely not related to anemia – pulmonary thromboembolism could be a possible cause of the dog's decline. Complainants commented that they wanted to see what the internal medicine doctor suggested as a next step. Dr. Deer explained that her associate, Dr.

Meredith, would reach out to them once they open. The case was transferred to Dr. Meredith at 7:00am.

42. Dr. Meredith reviewed the case with Dr. Deer – since his last visit, the dog had been started on sildenafil by a cardiologist due to a diagnosis of pulmonary hypertension and due to the concern of IMHA the dog was taken off zonisamide. Dr. Meredith evaluated the dog and noted the dog was obtunded and laterally recumbent.

43. When Dr. Schnier arrived at work at BluePearl he had a message from Complainants – he called Complainants and was advised the dog was being hospitalized at 1st Pet Veterinary Centers. They discussed the dog's condition and Complainants requested Dr. Schnier call the veterinarians at 1st Pet Veterinary Centers to get an update. Complainants then asked if the dog should be transferred to BluePearl; Dr. Schnier responded that it may not be in the dog's best interest if he was not stable – 1st Pet should be able to provide the same level of care and treatment that BluePearl could provide. He stated that repeat advanced imaging of the dog's head and thoracic cavity could potentially provide additional information although advanced imaging was not available at BluePearl. Re-evaluation by the neurologist could be helpful but the dog would need to be stabilized prior to considering an MRI or CT.

44. Dr. Meredith spoke with Complainants that afternoon and expressed her concerns for the dog. The dog's mentation was not appropriate and had declined significantly from when she has seen him last. They discussed the ability of the dog to swallow at that time and Complainants requested the dog remain on oral keppra instead of injectable. Dr. Meredith was not convinced this would have any effect on the dog's mentation but they could try it.

45. Dr. Schnier then called Dr. Meredith to discuss the case – he suggested thoracic radiographs and Dr. Meredith stated that she would consider that diagnostic. At that time, she reported the dog remained obtunded although he was able to take oral medications. Dr. Schnier thought the dog's current state could be related to post-ictal event associated with seizures, and anticonvulsant treatment. He was also concerned about a stroke-like event and discussed that a CT or MRI could be considered for further evaluation if possible. Dr. Schnier and Dr. Meredith shared their concerns with the dog's quality of life. Dr. Schnier noted if there was a concern for pulmonary thromboembolism or ischemic stroke, treatment with enoxaparin could be added in addition to clopidogrel. Dr. Meredith stated she would keep them updated and discuss the details of their conversation with Complainants.

46. Dr. Meredith also spoke with Dr. Yeamans, the neurologist, regarding the case. Dr. Meredith stated that Dr. Yeamans also had concerns with the dog's mentation and quality of life. She felt the dog would either recover, or worsen. The dog may need a ventilator and may not be able to ever come off the ventilator after being put on. If the dog's mentation did not improve in 12 -24 hours, he would likely not recover.

47. According to Dr. Yeamans, Dr. Meredith reached out to her to contact Complainants as they did not seem to fully grasp the severity of the dog's clinical status and she had discussed humane euthanasia with them. Dr. Yeamans reviewed the case and contacted Complainants. She advised that she had been speaking with Dr. Meredith and they were concerned with the dog's quality of life. Dr. Yeamans also advised that the dog would not be stable to transfer, nor undergo anesthesia for further investigations into his mental state, due to his respiratory compromise. She told Complainants that she was speaking with Dr. Meredith to advise on further care for the dog and options for treatment to help the dog return to a more normal mental status. However, all efforts had not shown significant improvement in the dog's clinical status.

48. Dr. Meredith called Complainants to relay her conversations with Dr. Schnier and Dr. Yeamans. She also advised that the dog had a seizure in the oxygen chamber, which meant the dog had a grave prognosis and was less likely to recover. Dr. Meredith attempted to contact a traveling internal medicine specialist without success. She told Complainants that she was worried the dog would not make the transport to another facility to be evaluated by internal medicine specialist; the dog was oxygen dependent and had another seizure. Dr. Meredith would reach out to their criticalist for a possible consult (she was unavailable until the next day). Complainants were to consider humane euthanasia.

49. According to the medical records, it appeared the dog was getting oral medications.

50. Dr. Deer took over the dog's care. She evaluated the dog – he was obtunded and minimally responsive, similar to when she observed him earlier that morning. Dr. Deer stated that around 7pm, before her evaluation, the dog began to flail and develop nystagmus, lost control of bowel movement and urine. There were concerns of seizure vs another vascular event. At this time, the dog had mild bradycardia and increased respiratory rate and effort.

51. The dog remained obtunded through the night and only became alert for medications. He was uninterested in food or water therefore his medications required to be force fed.

52. On 6/26/20, around 7am, Dr. Deer contacted Complainants with an update. She explained there was no change – the dog was still tachypneic, oxygen dependent, and minimally responsive. There was no interest in food and had to be forcefully medicated orally. Dr. Deer had another discussion with respect to the dog's quality of life, and humane euthanasia. Complainants wanted to have the dog euthanized at home therefore Dr. Deer stated they would continue to treat the dog until they could find an in-home euthanasia service.

53. The dog's care was transferred to Dr. Meredith. Dr. Meredith stated that Complainants called to advise the euthanasia appointment had been scheduled between 1 – 2pm that day therefore she did not follow up with the criticalist. Due to the dog's status, he was unable to take his oral medications therefore none was given and the dog was discharged

later that day.

COMMITTEE DISCUSSION:

The Committee discussed that they felt Dr. Meredith's treatment and communications were appropriate and professional. They felt there were expectations by Complainants that were unrealistic. Dr. Meredith and the premises went above and beyond to care for the dog. She did reach out and communicate with the dog's internal medicine specialist and neurologist. The veterinarians did coordinate and communicate in the care of the dog, which the Committee found impressive based on the differing schedules.

The dog received the best care possible and it unfortunately did not work out.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the Veterinary Practice Act occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 4 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
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10/16/20

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Oct. 16, 2020 Case Number: 21-46

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Dr. Nicolette Meredith

Premise Name: 1st Pet Veterinary Centers

Premise Address: 5404 E Southern Avenue

City: Mesa State: AZ Zip Code: 85206

Telephone: (480) 924-1123

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Frederick Milens and Ashanna Biliter

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: [redacted] Cell Telephone:

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. **PATIENT INFORMATION (1):**

Name: C[redacted]

Breed/Species: Pomeranian

Age: 14 Sex: M Color: Blonde

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

See attached list of veterinarians.

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

See list of veterinarians.

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: [signature] III

Date: October 11, 2020

Witnesses/Doctors

Dr. Jonathan Schnier
BluePearl Veterinarian Partners – Avondale
13034 W Rancho Santa Fe Blvd
Avondale, AZ 85392
(623) 385-4555

Dr. Courtney Deer
Dr. Nicolette Meredith
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1st Pet Veterinary Centers
5404 E. Southern Avenue
Mesa, AZ 85206
(480) 924-1123

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COMPLAINT SUMMARY

The Board should find that Dr. Meredith violated A.R.S. § 32-2232(23) as well as violated R3-11-501(1). Dr. Meredith violated 32-2232(23) when she neglected C[redacted] care when she failed to coordinate with internal medicine or critical care despite her assertion that she would do so. Further, she was also responsible for a portion of C[redacted]'s care when they failed to administer any medicine to him for almost half a day. This conduct was not only detrimental to C[redacted] health but also made it difficult to tell what exactly was causing his issues. 1st Pet also did not appear to be monitoring C[redacted] closely with a jingle collar or other device to inform them that he was having seizures when they were not watching him.

Dr. Meredith also violated R3-11-501(1) when she failed to show respect for C[redacted]s us as C[redacted] owners, or use professionally acceptable procedures. Dr .Meredith failed to relay to us any of Dr. Schnier's recommendations although she knew that she was C[redacted] emergency care provider and Dr. Schnier had the history of providing C[redacted] with appropriate care. Further, although she was the veterinarian responsible for some of C[redacted] care when he stayed overnight, we were not updated with C[redacted] severe decline when we told the staff to keep us apprised of any significant changes no matter the time of day (or night).

As a preliminary note, C[redacted] has long-suffered from seizures and we have been very involved in his care and the different procedures used for his care so that we could give him the best quality of life and best chance of managing his seizures. The following is a summary of the concerns that we have and the history of Dr. Meredith's involvement in C[redacted] care around the time of C[redacted] passing.

FACTUAL NARRATIVE UNDERLYING THE COMPLAINT

Dr. Meredith (along with Dr. Deer, mentioned in a separate complaint) first treated C[redacted] at 1st Pet Mesa's emergency on June 19, 2020 and June 20, 2020 following an episode of collapse. Tests were performed at that time and initial supportive treatment provided including placing C[redacted]n oxygen. She also stated that C[redacted] may need to be seen by one of their internal medicine specialists depending on his condition, but no coordination with internal medicine or critical care at 1st Pet Mesa occurred. The following day she believed that C[redacted] might be ready for discharge as he seemed stable, i.e. no worse now than he was when he came in post-collapse. We came to visit him and see how he was doing, and after remarking that C[redacted] seemed to be doing a lot better in our presence, she felt comfortable discharging him to us.

Dr. Meredith (also along with Dr. Deer) was also responsible for portions of C[redacted] care during his subsequent hospitalization at 1st Pet Mesa after his episode on June 24th following discharge from BluePearl Avondale. C[redacted] declined significantly while at 1st Pet Mesa, particularly over his first night, based on our own subjective evaluations of him during our visits that night and the following morning; we were not updated as to the decline overnight and only learned of it in full the next morning. He was, however, able to take his pills and displayed some mild awareness when people would interact with him.

Late on June 25, 2020, Dr. Meredith informed us that she had spoken with both Dr. Schnier and Dr. Yeamans and that all three were in agreement regarding C[redacted] current quality of life being unacceptable and that euthanasia was in order. I wanted to ensure that all possible avenues had been exhausted before committing to euthanasia and asked as to the possibility of a transfer. I had previously spoken with AVECCC about the possibility of a transfer and had been informed that the transfer would have to start with his current veterinarian rather than myself. Dr. Meredith stated that she felt that AVECCC would not provide additional capabilities and that it would be unlikely for C[redacted] to survive the transfer. She also said that she would speak to the critical care specialist at 1st Pet Mesa and obtain their opinion, but we also never heard anything back regarding that.

Based on the information provided, we proceeded with in-home euthanasia on June 26, 2020. When we picked up C[redacted] to bring him back home for euthanasia, he was largely unaware but seemed aware enough to know that he was back with us, as he calmed down significantly on my lap. Also, using an oxygen tank on the ride home, C[redacted] was so peaceful that we were concerned that he had passed away in transit, counter to Dr. Meredith's concerns that he would not be able to be transported to another facility. C[redacted] also survived for almost an hour at home prior to euthanasia and seemed to display at least some low-level awareness of being at home before he died, even though he seemed to be having very brief, small seizure-like activity.

Additionally, based on BluePearl's records of the conversation with Dr. Schnier and Dr. Meredith, while very guarded in terms of prognosis, Dr. Schnier was far more subtle in terms of his evaluation than we were led to believe and suggested other actions out of due diligence prior to euthanasia. I cannot compare Dr. Meredith's perspective of the conversation as no notes regarding her conversations with Dr. Schnier or Dr. Yeamans were present in the records provided to me, records which I was assured at the time were complete and contained all communication records. According to BluePearl's records, Dr. Meredith told Dr. Schnier that this information would be relayed to us, but this did not occur, and I am also skeptical that any of Dr. Schnier's recommendations were acted on at 1st Pet Mesa.

In addition, I am unsure to what extent 1st Pet Mesa followed C[redacted] antiseizure protocols when seizures were reported, as C[redacted] has a history of cluster seizures, and particularly as his zonisamide had been discontinued *abruptly* based on medical advice from 1st Pet Mesa and Dr. Yeamans. Nearly *all* of C[redacted] medications, including his primary antiseizure medication, were discontinued for almost half a day; this would make it challenging for us to determine in the context of euthanasia whether some of the obtundedness would have been the result of seizure activity or the result of stroke or other damage to the brain. C[redacted] did have one seizure-like event in hospital as well as what appeared to be small seizures at home while waiting for euthanasia, so I do wonder if he was having other small seizures that went unnoticed. There did not appear to be a "jingle collar" or any other means of alerting staff to a seizure during our visits. (Note that many of these concerns can also apply to Dr. Deer's shifts.)

I would also note that despite 1st Pet Mesa's mentions of the availability of internal medicine and critical case specialists at the facility, it appears that at no time during either of his hospitalizations was he ever examined by a specialist, nor is there any record that his case was

discussed with any in-house specialists during that time. Given that Dr. Deer indicated that they weren't actually available on the previous weekend, and that Dr. Meredith never replied regarding a consultation with critical care, I am skeptical that such resources are generally available to their emergency department regardless of any verbal or marketing claims to the contrary.

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received 11/16/20

Dr. Meredith

To whom it may concern,

I am writing to you in response to a complaint filed by Frederick Milens and Ashanna Biliter on October 11th in regard to my care over their pet C[redacted]. C[redacted], a 14-year-old Pomeranian, presented to me for collapse on June 19th at 4:32pm. C[redacted] has a history of multiple medical issues and has been on a combination of seizure medications. The owner described that C[redacted] laid lateral in the yard and had turned his head to the side. C[redacted] also had 2 previous episodes at home that started the night before. Mr. Milens told me that they had administered another dose of Keppra and he seemed fine after. Mr. Milens also described another episode that happened later in the day wherein C[redacted] had urinated on himself and had turned pale in color. On presentation, C[redacted] was alert and responsive, had muddy gums, and was having some difficulty breathing. C[redacted] neurological exam was abnormal, as he did not have menace response in either eye. C[redacted] heart rate was low and his lungs were harsh. C[redacted] had an IV catheter placed and was placed in an oxygen chamber for support after learning that his oxygen levels were low. After placing C[redacted] in the chamber, an ECG revealed a normal rhythm and rate, as well as a normal blood pressure.

After supplying adequate amounts of oxygen, my staff moved forward with his initial diagnostics. Chem 17 profile showed a moderate anemia (RBC 2.47M/uL and PCV 22%), leukocytosis with neutrophilia and monocytosis, elevated BUN (42), ALT (187), ALP (1758), GGT (51), and amylase (5085). Blood gas did show a mild metabolic acidosis (7.282), decreased bicarbonate, hyperkalemia (5.0), and low pO2. Radiographs showed on initial exam, a mildly enlarged heart with a bronchial pattern worse in the left lung fields, spondylosis, and aeophagia. The radiology report later noted collapse of the left bronchus, enlarged liver, and some abnormal gastric contents. Due to the anemia, a saline agglutination test was run and was concerning for agglutination. I discussed at length with the owner about the abnormal diagnostics. Mr. Milens informed me that C[redacted] has a history of kidney disease as well as a left-sided stroke and absent menace of the right eye. I mentioned the possibility of immune mediated hemolytic anemia (IMHA) due to the anemia and elevated white blood cell count, but I stated that the saline agglutination test was not very supportive. We discussed primary IMHA, which is unlikely at his age, and secondary IMHA, which may be related to an underlying infection, medications, cancer, etc. Furthermore, I expressed my concern for a possible pulmonary thromboembolism (PTE), considering the history of stroke and C[redacted] oxygen dependence. Other causes for the respiratory distress are bronchitis and pneumonia. We discussed, at length, possible underlying causes, and that at this time we could treat with steroids, antibiotics, and oxygen. We would continue to monitor his response. I also stated my concern for the myriad of other health issues. I told Mr. Milens that C[redacted] prognosis was guarded-to-poor, and that if he continued to have issues, we may need to discuss quality of life. Mr. Milens understood and approved the plan for hospitalization. Mr. Milens also let me know that they had an appointment with their internal medicine specialist on Monday. I then transferred over his care at 7pm to Dr. Courtney Deer. On June 20th, I took back over the case from Dr. Deer. C[redacted] PCV overnight was between 17% and 20%, and a saline agglutination test was repeated. The test again revealed a mild positive response, and a blood smear did confirm spherocytes and polychromasia. C[redacted] was weaned down on his oxygen levels overnight, but

was not able to fully discontinue oxygen therapy. Dr. Deer also noted the owner's concern for Zonisamide being a cause for the IMHA. She explained that there is a risk to lowering Zonisamide and that rebound seizures can occur. The owner elected to move forward with lowering the dose at that time.

I continued supportive care for C[redacted] throughout the day. C[redacted] seemed very comfortable and was breathing more normally when he was not being disturbed for his vitals and medications. When placed into his oxygen kennel, however, he became more distressed and his respiratory rate and effort would climb. I recommended that the owners come see how C[redacted] interacted with them that evening. Prior to their visit, we had turned the oxygen levels down to about room air levels, and his respiratory rate and effort were low. The owners then visited with C[redacted] and elected to take him home because he seemed more relaxed with them. I told them that they needed to keep their appointment on Monday to see their internal medicine doctor.

C[redacted] presented to our hospital on June 24th during Dr. Deer's shift. I took over C[redacted]s care on June 25th at 7am. Dr. Deer rounded to me and stated that C[redacted] may have had another collapse/seizure episode at home after receiving a blood transfusion. C[redacted] d also been diagnosed with pulmonary hypertension and was started on Sildenafil by a cardiologist earlier that week. Due to the concern of IMHA, C[redacted] had also been taken off of his Zonisamide prior to entry. During my physical exam that morning, C[redacted] was obtunded and again laterally recumbent. His abdomen was tense and distended and his lung sounds were harsh and he had a moderate effort when breathing.

I told Mr. Milens that afternoon that I was worried about C[redacted] His mentation was not appropriate and had declined significantly from when I had last seen him. I was worried about C[redacted]s overall prognosis. Mr. Milens informed me that he had called C[redacted]s other doctors and that they were planning to call me when they had a chance. Mr. Milens made a comment that everyone seemed very busy. We talked about C[redacted] ability to swallow at that time, and Mr. Milens asked that we give him his oral Keppra instead of an injection. I told Mr. Milens that I did not think that this would have any effect on C[redacted]s mentation but that we could try it.

I spoke with Dr. Schnier(internal medicine) and Dr. Yeamans (neurology) about C[redacted] condition later on that afternoon and evening. Dr Schneir was also concerned about PTE and his overall mentation; he recommended starting Clopidogrel to hopefully help prevent further clots from being thrown. However, he stated that C[redacted]s overall mentation is something that may or may not improve. Dr. Schneir said that even if we were able to get C[redacted] through this episode, his recovery would be very rough, and he also had quality-of-life concerns. Dr. Yaemans also had concerns about C[redacted]nentation and quality-of-life. She had spoken with the owner and called me to relay the information. At that time, she told me that C[redacted] would either recover or he would worsen. She stated that C[redacted] may need a ventilator and may not be able to ever come off the ventilator after being put on. If his mentation did not improve in 12-24 hours, then he likely would not recover.

I relayed the information from Dr. Schnier and Dr. Yeamans to Mr. Milens. I also explained to him that C[redacted] had a seizure while in the oxygen chamber, which meant that he was less likely to recover and had a grave prognosis. I told the owner that I tried to contact some traveling internal medicine specialists but that no one was available. We discussed transporting C[redacted] to another facility to get worked in through their emergency department in order to be seen by their internal medicine specialist, but I stated that I was worried C[redacted] may not make the transport in his condition. C[redacted] was oxygen dependent and had another seizure. We discussed quality of life again and the owner let me know that he was also concerned. Mr. Milens told me that he would talk with Ashanna about possible euthanasia. I told the owner that I would try and contact our criticialist, but that she may not be available for consult.

I texted the criticialist, and she told me that she was unable to look at the case until the following day. I let her know that the owner was considering euthanasia if C[redacted] did not improve overnight. I told her that if they wanted to move forward with further care, I would let her know. I transferred the case back to Dr. Deer for overnight care.

The next morning, on June 26th, I rounded with Dr. Deer, and she let me know that the owners were electing to euthanize and that they were going to bring him home. They were coordinating with an at-home euthanasia provider. Dr. Deer told me that they would be calling back with a more specific time. The owners called us back and let us know that they had it scheduled between 1-2pm that day. Due to what the owners had told Dr. Deer about moving forward with euthanasia, I did not contact our criticalist to review the case as the owners had elected to not continue further care. Due to C[redacted]s status, he was unable to take his oral medications, so none was given. The IV catheter was left in place and the owners came and picked up C[redacted] I had no further communication with the owners at this point.